Exhibit 2



AMS CONTRACT

June 30, 2011

Harris County Hospital District

Where People Come First.

Ben Taub General Hospital • Lyndon B. Johnson General Hospital • Quentin Mease Community Hospital • Community Health Program

History of AMS Contract

- AMS is a 501(c)3 comprised of UTHSC and BCM, formed to contract with HCHD in 1989
- Required anti-trust exemption from the Texas State Legislature
- 20 year Agreement
- Renegotiated in 2007, effective June 30, 2008

History of AMS Contract

- Previous contract:
  - Paid for fixed full time equivalents (FTEs)
  - No requirement for faculty attendance
  - No requirement for production
  - No incentive for collections
  - No transparency of information
  - Closed medical staff
  - Replaced June 30, 2008

History of AMS Contract

- Current contract:
  - Contract between to AMS and HCCS
  - HCHD became HCCS's operating manager
  - 5 year term with annual "evergreen"
  - Allows for payments based on quality
  - No requirement to use AMS to staff new facilities
  - Schools required to use "best effort" for collections

History of AMS Contract

- Current contract:
  - Faculty compensation equals:
    - Salaries, fringes and call
    - Plus 18% of compensation as overhead
    - Less schools' collections
  - "Risk adjusted" by Production Risk Corridor
    - Based on relative value units (RVUs)
    - Based on service line, not individual production

History of AMS Contract

- Current contract:
  - "Risk Adjusted" by Production Risk Corridor
    - +/- 15%, based on Academic National MGMA Production Survey (rolling 3 year average of median)
    - If Service Line produces at median, then 100% of salaries and fringes paid

History of AMS Contract

- Current contract:
  - Leadership paid separately
    - Based on salary and fringes for FTE fraction, plus 18% overhead
  - GME paid separately
  - More transparency of data
  - No requirement to use AMS to staff new facilities (El Franco Lee)

Benefits of Current Contract

- Better charge capture
- Faculty Production (RVUs) increased:

	2007	2008	2009	2010
UT	**641,746**	**752,782**	**831,733**	**944,713**
BCM	**1,029,011**	**1,123,876**	**1,163,179**	**1,540,712**
TOTAL	**1,670,757**	**1,876,658**	**1,994,912**	**2,485,424**

Benefits of Current Contract

- Faculty more engaged – clinical FTEs:

	2007	2008	2009	2010
UT	**197.29**	**197.29**	**194.90**	**220.72**
BCM	**323.34**	**323.34**	**314.88**	**365.88**
TOTAL	**520.63**	**520.63**	**509.78**	**586.61**

Annual Costs

(in thousands)

		2007	2008	2009	2010
FACULTY					
	UT - Clinical	$36,351	$36,351	$27,663	$31,959
	Overhead	$342	$342	$8,527	$9,355
	Salary Mkt Adj.*			$9,590	$9,590
	Total	**$36,693**	**$36,693**	**$45,780**	**$50,904**
	BCM - Clinical	$49,239	$49,239	$33,841	$49,124
	Overhead	$297	$297	$14,400	$16,111
	Salary Mkt Adj.*			$28,591	$28,591
	Total	**$49,536**	**$49,536**	**$76,832**	**$93,826**
RESIDENTS					
	UT	$10,146	$10,764	$10,873	$12,061
	BCM	$20,373	$20,164	$21,377	$22,022
	Total	**$30,519**	**$30,928**	**$32,250**	**$34,083**
TOTALS					
	UT	$46,839	$47,457	$56,653	$62,965
	BCM	$69,909	$69,700	$98,209	$115,848
		$116,748	**$117,157**	**$154,862**	**$178,813**
	***estimated**				

Additional HCCS Subsidy

		2007	2008	2009	2010
BCM	FACULTY	$0	$0	$796,356	$884,604
	GME	$0	$0	$1,127,544	$1,382,808
	TOTAL	$0	$0	$1,923,900	$2,267,412
UT	FACULTY	$0	$0	$692,400	$692,400
	GME	$0	$0	$1,038,600	$1,038,600
	TOTAL	$0	$0	$1,731,000	$1,731,000
TOTALS	FACULTY	$0	$0	$1,488,756	$1,577,004
	GME	$0	$0	$2,166,144	$2,421,408
	TOTAL	$0	$0	$3,654,900	$3,998,412

HCCS Data

Issues with Current Contract

- Collection Risk
- Medical Director Compensation
- Medically Unnecessary Procedures
- Call Pay Compensation
- Medical Leadership and Faculty Incentives
- AMS/Academic Model "Fit"
- Difference in interpretation of contract terms

Collection Risk

- Schools' investment(s) in Revenue Cycle increase their expenses, with no increase in revenue
- Results in subsidy of schools collections

Medical Director Compensation

- Pay based upon fraction of FTE devoted to leadership (salary, fringes plus overhead)
- No requirement for clinical time commitment
- Directors paid differently between schools, because salaries and fringes are different
- No similar methodology in Houston market; none found nationally

Medical Director Compensation

- Medical Director Pay is high focus compliance target, nationally
- Must be at FMV for time of physician
- Typically paid as monthly or annual stipend
- Typically paid according to local or national survey data, as indicators of FMV
- Must include time-keeping (done currently)

Medically Unnecessary

- No dis-incentive for, or incentive to avoid Medically Unnecessary:
  - Admissions
  - Procedures and tests
  - Inpatient days
  - Referrals
  - Test interpretation delays

Call Pay Compensation

- Methodologies not consistent between schools
- Methodologies not consistent within each school
- Various methodologies typically employed, appropriate to service line, but based upon local or national surveys

Medical Leadership & Faculty Incentives

- Leadership/Faculty not yet incented for:
  - quality metrics
  - resource utilization metrics
  - customer service metrics
- Current environment <u>needs</u> focus on all the above
- ACO environment, as currently defined, <u>requires</u> focus on all the above

AMS/Academic Model "Fit"

- Greater input needed on selection of Medical Leadership
  - To move to "ACO" model
- Greater flexibility on how facilities are staffed needed
  - To fill vacancies quicker
  - To change staffing models to fit changing customer needs

AMS/Academic Model "Fit"

- Independent contractors vs. employed physicians
- Collections, salaries, fringes - transparency
- Managed Care contracting
- School cooperation, central coordination
- Usefulness in ACO environment
- Education vs. service

Interpretation of Contract Terms

- BCM invoices not furnished in format specified
- Both Audits found it difficult to obtain supporting documentation and audit

Next Steps

Change methodology from "Cost Based" to "ACO Compatible," i.e. pay schools based upon quality, resource and customer service metrics, by January 1, 2012 (announced date for first phase of implementation of ACOs)

Next Steps

- Eliminate collections risk by benchmarking schools, based upon national survey data (July 1, 2011)
- Pay Medical Directors according to national survey data
- Include basic disincentives for unnecessary use of resources (tests, admissions, etc.); add more, over time, to prepare for ACOs

Next Steps

- Pay for Call consistently, by service line across both schools, benchmarked to national surveys
- Incent leadership/faculty based upon quality, resource and customer service metrics

Next Steps

- Increase ability of HCHD to:
  - Select Medical Leadership
  - Fill vacancies, if not filled by AMS within reasonable time
  - Change staffing models and move resources to accommodate patients
  - Employ providers where “AMS/academic model” does not satisfy needs of patients

Next Steps

- Clarify contract terms
  - Show calculation detail on invoices
  - Use proper invoice format
  - Define “Fringes”
  - Provide supporting documentation (source documents)

Discussion

Status of Schools Assumption of Collection Risk

Options

Do Nothing:

- Pros:
  - Easiest path
  - HCHD has organized an active PIT to help AMS improve their revenue cycles
  - BCM hired a turnaround team
- Cons:
  - HCHD has a fiduciary responsibility to use resources appropriately
  - May not be politically viable

Options

Reduce IGT payments equal to collection deficits:

- Pros:
  - Good stewards of taxpayers' money
  - Politically correct
- Cons:
  - A fair benchmark for calculating deficits must be determined
  - Strains school partnership
  - Strains HCCS partnership